



# Application for Health Care Coverage

(and to find out if you can get help with costs)

(4114 15 1114 5411 75	d can get help with costs)
Use this application to see what health care coverage you qualify for:	<ul> <li>Free or low-cost health care coverage from Washington         Apple Health (Formerly called Medicaid) or the Children's         Health Insurance Program (CHIP)</li> <li>A new tax credit that can help you pay your health care premiums</li> <li>Private Qualified Health Plans</li> </ul>
Apply faster online	Apply faster online at www.wahealthplanfinder.org
Information you will need to apply:	<ul> <li>Social Security numbers</li> <li>Birthdays</li> <li>Foreign passport, alien, or other immigration numbers for any legal immigrants who need health care coverage</li> <li>Income information for all adults and all minors who are required to file a tax return</li> <li>Information about health insurance available to your family</li> </ul>
Why do we ask for so much information?	We need the following information in order to determine what health care coverage you are qualified for. We will keep the information you provide private as required by law.
Send your complete and signed application to:	Washington Healthplanfinder PO Box 946 Olympia, Washington, 98507 or Fax 1-855-867-4467 If you don't have all the information we ask for, you can start your application by filling in your name, date of birth, signature, and address and mail to the address above.
Get help with this application:	<ul> <li>Online: www.wahealthplanfinder.org</li> <li>Phone: Call the Customer Support Center at 1-855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)</li> <li>In person: To get application assistance search for a Navigator or Broker via the customer support link at www.wahealthplanfinder.org.</li> <li>Language or Disability: To get free help in your language or a disability accommodation, call 1-855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)</li> </ul>

#### **Definitions**

**Health Insurance Premium Tax Credits:** Tax credits available to help pay for health care coverage premiums for individuals and families with income below 400% of the federal poverty level (FPL), but above 100% of the FPL. FPL can be found at http://aspe.hhs.gov/poverty/index.cfm

**Washington Healthplanfinder:** An online marketplace for individuals, families and small businesses in Washington to compare and enroll in health insurance coverage and gain access to tax credits, reduced cost-sharing, and public programs such as Washington Apple Health.

**Premium:** A monthly payment to a health insurance company for health insurance.

**Qualified Health Plan:** A health care coverage policy that is sold through the Washington Healthplanfinder.

**Minimum Essential Coverage:** This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE and other coverage that covers the 10 Essential Health Benefits.

**Washington Apple Health:** The public health insurance programs for eligible Washington residents. Washington Apple health is the name used in Washington for Medicaid, the Children's Health Insurance Program (CHIP), and state-only funded health care programs.

#### For people who are self-employed

You can subtract the costs below from your gross income to get an amount for your net self-employment income. For more information, see "Instructions for Schedule C" at <a href="https://www.irs.gov">www.irs.gov</a>.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals







#### Health Care Coverage Rights and Responsibilities

### Your rights (wemust) for all health care coverage programs

Help you read and fill out all requested forms. For assistance you can contact Washington
Healthplanfinder or if you are an individual who is aged, blind or disabled or in need of long-term services and supports (LTSS) you can contact the Department of Social and Health Services (DSHS).

**Provide interpreter or translator services** at no cost to you and without delay when communicating with WashingtonHealthplanfinder or DSHS.

**Keep your personal information private** but we may share some information with other state and federal agencies for purposes of eligibility and enrollment.

Give you the opportunity to appeal if you disagree with a determination made by Washington Healthplanfinder or DSHS that affects your eligibility for health coverage, LTSS, a health plan, health insurance premium tax credits, or cost-sharing reductions. By asking for an appeal, your case will be reviewed. You can find more information about the Healthplanfinder appeals process by visiting the Healthplanfinder Appeals Page at http://wahbexchange.org/appeals/or contacting the Healthplanfinder Customer Support Center at 1-855-923-4633. For information about appeals for DSHS programs, you may contact DSHS Customer Service Contact Center at 1-877-501-2233 or visit your local Home and Community Services Office.

If the appeal is for a decision on Washington Apple Health coverage, which is unresolved by a case review, you will be scheduled an Administrative Hearing.

**Treat you fairly** without regard to your race, color, political beliefs, national origin, religion, age, gender (including gender identity and sex stereotyping), sexual orientation, disability, honorably discharged veteran or military status, or birthplace. To file a complaint of discrimination, you contact the U.S. Department of Health and Human Services at:

http://www.hhs.gov/ocr/civilrights/complaints; or

Regional Manager, Office for Civil Rights
 U.S. Department of Health and Human Services, 2201
 Sixth Ave. – M/S: RX-11
 Seattle, WA 98121-1831
 Voice phone 800-368-1019
 Fax 206-615-2297
 TDD 800-537-7697.

### Your responsibilities (you must) for all health care coverage programs

SSN and Immigration Status Disclosure. With some exceptions, you must provide a Social Security Number (SSN) or immigration document number of yourself or anyone else in your household who wants to apply for health care coverage. An SSN is required to apply for health insurance premium tax credits. We use this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. We do not share this information with any immigration agency.

It is possible to apply for coverage for some members of your household, but not others. If you do not have an SSN or immigration document number for all household members, others can still apply for and get coverage. There are also some Washington Apple Health programs for people who cannot show they are in the country legally. But if you choose not to provide an SSN or immigrant document number for someone in your household, we will need to follow up with you to get information about the non-applicant's income.

**If requested by the agency**, provide any information or proof needed to decide if you are eligible.

## Things you should know for all health care coverage programs

There are certain state and federal laws that govern the operation of Washington Healthplanfinder and state-administered application systems, your rights and responsibilities as someone who uses them and the coverage you get from using them. By using these systems, you agree to comply with the laws that apply to someone using them and the coverage they get as a result.

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at www.vote.wa.gov or order voter registration forms by calling 1-800-448-4881.

Health Insurance Portability and Accountability Act (HIPAA) restrictions prevent the Health Care Authority (HCA) and DSHS from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

The Affordable Care Act prevents the Washington Healthplanfinder and DSHS from giving the personally identifiable information (PII) of you or any member of your household to anyone who is not authorized to receive it, and without your consent.

The information that you give Washington

Healthplanfinder and DSHS is subject to verification by federal and state officials for purposes of determining your eligibility for health care coverage. Verification can include follow-up contacts from agency staff.

If you begin completing an application for health insurance on Healthplanfinder and do not complete the process for any reason, your information will be stored in Healthplanfinder and accessible by you for 90 days. If you do not complete an application after the 90-day period, your information will be deleted from the Healthplanfinder system.

Washington Healthplanfinder, HCA and DSHS are not responsible for administering your health insurance plan. Your health insurance carrier can provide you more information about your benefits. If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier. If you are eligible for COBRA following the termination of any health insurance coverage purchased through Healthplanfinder, administering COBRA and providing you the required COBRA notices and election periods is youremployer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you selected. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

You may apply for support enforcement services through the Division of Child Support (DCS).

To get an application for these services, go to www.childsupportonline.wa.gov or contact your

## Your rights (we must) for Washington Apple Health only

local DCS office.

**Explain to you your rights and responsibilities** if you ask.

Allow you to submit a partial application that includes at minimum, your name, address, and signature or the signature of the applicant's authorized representative. The day we get a partial application is your application date, which may affect when your coverage becomes effective. We will not make a final decision about your coverage until after you complete the application.

Allow you to submit an application or partial application using any method listed under WAC 182-503-0005.

**Process your application promptly** and no later than the timelines described in WAC 182-503-0060.

**Give you 10 calendar days** to provide information we need to determine eligibility. If you ask for more time, we will give you more time. If you don't give us the information or ask for more time, we may deny, close, or change your healthcare coverage.

**Help you** if you have trouble getting any information or proof needed for us to decide if you are eligible. If we require a document that will cost you money, we will send for it and pay the cost.

**Notify you, in most cases, at least 10 days** before we stop your healthcare coverage.

**Give you a written decision,** in most cases, within 45 days. Health care coverage for some disability cases may take up to 60 days. We give a written decision on pregnancy medical within 15 days.

Allow you to refuse to speak to an investigator if we audit your case. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for health care coverage.

**Continue Washington Apple Health coverage** while we decide if you are eligible for another program per WAC 182-504-0125.

**Give you equal access services** as described in WAC 182-503-0120 if you are eligible.

#### Your responsibilities (you must) for Washington Apple Health only

**Report changes as required** in WAC 182-504-0105 and WAC 182-504-0110 within 30 days of the change. Read your approval letter to see what changes you must report.

Complete renewals when asked.

**Give medical providers information** needed to bill us for health care services.

Apply for Medicare if you are entitled to it.

Cooperate with Quality Assurance staff when asked.

**Apply for and make a reasonable effort** to get potential income from other sources when you ask for or receive Washington Apple Health coverage.

## Things you should know for Washington Apple Health only

**By asking for and receiving Washington Apple Health**, you give the state of Washington all rights to any medical support and to any third party payments for health care.

**The Agency may share** your child's immunization history with the Child Profile Immunization Tracking System.

**Information you report** may be provided to DSHS to determine eligibility and monthly benefits for programs such as health care coverage, cash assistance, food assistance and child care subsidies.

By law, the State of Washington may recover the costs it paid for certain types of medical services from your estate through Estate Recovery (RCW 41.05A.090, RCW 43.20B.080, and Chapter 182-527 WAC). Estate Recovery doesn't happen until after your death, the death of your surviving spouse, and yoursurviving

children are age 21 or older. It also doesn't happen if a surviving child was blind/disabled at your time of death. Recoverable costs include:

- Certain Washington Apple Health long-term services and supports, if you're age 55 or older at the time you received the services;
- Certain state-only funded services, regardless of your age at the time you received the services.

The State may also file a pre-death lien on your real property, at any age, if you become permanently institutionalized (WAC 182-527-2820). The State may recover from a sale of the property, or your estate, unless:

- Your spouse lives at the property;
- Your sibling lives at the property, is a co-owner, and meets certain conditions.
- Your child lives at the property, and is blind/disabled; or
- Your child lives at the property and is younger than age 21.

You can find a list of services subject to cost recovery under WAC 182-527-2742. You can find a list of assets excluded from recovery under WAC 182-527-2754.

You may be restricted to one health care provider, pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

## Things you should know for qualified health plans only

If you enroll in a qualified health plan through Healthplanfinder and do not provide enough information to verify your eligibility, or information that cannot be verified, you will have 90 days to provide what is needed. During this time, you should work with Healthplanfinder staff to help provide any missing information or clear up any remaining questions. This will help get you coverage as soon as possible.

#### If you enroll in a qualified health plan through Healthplanfinder and you have a change in income,

you should notify Healthplanfinder as soon as possible. A change in income could change the tax credits or cost-sharing reductions you should get. You could be eligible for a lower-cost plan, because of a change in your income, or you could be required to pay back a part of a tax subsidy you get, if your income increases and you do not report it.

Rates shown are subject to change based on the health insurance carrier's underwriting practices and your choice of any available options.

Final rates are always determined by the health insurance carrier.

Rates shown are for your requested effective date

**ONLY.** If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates above, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time. Your coverage will not be active until your insurer confirms receipt of payment.

You consent to the Washington State Employment Security Department's release of your wage and employment data to Washington Healthplanfinder and DSHS. You acknowledge that granting this consent will help simplify the application and redetermination process for Washington Healthplanfinder. Your personal information will be protected as described in the Notice of Privacy Practices.





# **Application for Health Care Coverage**PART 1

Primary Applicant Name and Contact Information							
First Name, Middle Initial, Last Name & Suffix			Date	of Birth (MM/DD/YYYY)		Sex M F	
Signature of Primary Applicant or Auth	norized Represer	ntative (Requ	uired)		•		
x				<u> </u>			
Are You Without A Fixed Address? [Check yes if you do not have a home a lf yes, in what county would you like to		need to pro		ailing address.			
Address Where You Live	J receive fleattif	City					
Address where rou live		City		County	State	Zip code	
Mailing Address (If Different)		Cit	ΣУ		State	Zip Code	
Primary Phone Number  Cell Home Work  ( )	Secondary Phone Number  Cell Home Work  ( )		E-mail Address	255			
Washington Healthplanfinder may need to contact you regarding the status of your application and/or request additional information. What is your preferred method of contact?							
Language Information							
Do you or anyone you are applying for want an interpreter and to receive documents in a language other than English?  No Yes If yes, what language or alternative format do you need? List all that apply:							
<b>Authorized Representative In</b>	nformation						
1. An authorized representative is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes.					d is		
<ol> <li>Please note: This is different than partnering with a Navigator or a Broker.</li> <li>By designating an authorized representative, you are giving permission for your authorized representative to:</li> </ol>							
<ul> <li>Sign the application on your behalf;</li> <li>Receive notices related to your application and account; and</li> <li>Act on your behalf for all matters related to the application and account.</li> </ul>							
a. Are you designating an authorized representative? $\square$ No $\square$ Yes							
b. Do you want your authorized representative to receive notices related to your application and account? $\square$ No $\square$ Yes					□ No □ Yes		
Authorized Representative Name / Organization Phone Number							
Mailing Address of Authorized Representative			Address				

1

HCA 18-001P (9/15)



#### **Information About Your Family** You don't need to file taxes to apply for health care coverage. You must include these individuals on your application: your spouse, your children who live with you, all parents living in the home with their child, and anyone you expect to claim on your federal income tax return, if you file one. If you expect to be claimed as a tax dependent on someone's tax return, you must include all members of the tax filing household claiming you and any family members living with you. **Primary Applicant** First Name M.I. Last Name Date of Birth (MM/DD/YYYY) Sex M Is this Person Applying for Health Care Coverage No Yes F Relation to You **SELF** (For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional) Citizen or Non-Citizen Status: (check one) U.S. Citizen Non-Citizen Lawfully Present In the U.S. Social Security Number (SSN):\_\_\_\_\_\_\_\_If lawfully present Non-Citizen, enter the following information: Foreign Passport Number: \_\_\_\_\_\_; Country of Issuance: \_\_\_\_\_\_; Date of Entry: \_\_\_\_\_ If you do not have this information, enter your "A" number and receipt number or other immigration number: **Expected Tax Filing Status for the Current Year (select one)** Adult disabled tax dependent of someone on the ☐ Single filing taxes application Head of household ☐ Tax dependent of someone on the application Qualifying widow(er) with tax dependent Adult disabled tax dependent of someone **not** on the ☐ Married filing separately application Married filing jointly: Tax dependent of someone **not** on the application Name of primary tax filer: ☐ Person has neither filed taxes nor was tax Did you have the same tax filing status last year as the current year listed above? \(\subseteq\) No \(\subseteq\) Yes If no, list last year's tax filing status: (Your response to this question does not affect your eligibility for Apple Health) If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax RACE / ETHNICITY CODE (OPTIONAL – check all that apply) If American Indian or Alaska native, do not enter a race or ethnicity White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other Are you an American Indian or Alaska Native? ☐ No ☐ Yes Spouse or Other Parent (If living in the home) First Name M.I. Last Name Date of Birth (MM/DD/YYYY) Is this Person Applying for Health Care Coverage Sex Relation to You (i.e. spouse, domestic partner, partner) ∏М ∏ F No (For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional) Citizen or Non-Citizen Status: (check one) U.S. Citizen Non-Citizen Lawfully Present In the U.S. Social Security Number (SSN):\_\_\_\_\_\_\_\_ If lawfully present Non-Citizen, enter the following information: Foreign Passport Number: ; Country of Issuance: ; Date of Entry: If you do not have this information, enter your "A" number and receipt number or other immigration number: **Expected Tax Filing Status for the Current Year (select one)** Adult disabled tax dependent of someone on the ☐ Single filing taxes ☐ Head of household Tax dependent of someone on the application Qualifying widow(er) with tax dependent Adult disabled tax dependent of someone **not** on the ☐ Married filing separately application Married filing jointly: Tax dependent of someone **not** on the application Name of primary tax filer: Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last If no, list last year's tax filing status:				es
(Your response to this question does not a If you are submitting this application between				vnact to file with the same tay
		Yes	tilis caleridar year, do you e	spect to me with the same tax
RACE / ETHNICITY CODE (OPTIONAL – chec	k all tha	t apply)		
If American Indian or Alaska native, do not				
☐ White ☐ Black or African American ☐	Asian	☐ Native Haw	raiian 🗌 Pacific Islander 🗌	Hispanic or Latino   Other
Are you an American Indian or Alaska Nativ				
(1.) List Children / Tax Depender	its/Ot	her Househ	old Members	
First Name	M.I.	Last Name		Date of Birth (MM/DD/YYYY)
Is this Person Applying for Health Care Cove ☐ No ☐ Yes	erage	Sex F	Relation to You (i.e. child, gra	andchild, nephew, niece, sibling)
(For individuals not applying for coverage, Citizen or Non-Citizen Status: (check one)	-	_	urity number (SSN) or citizen ] Non-Citizen Lawfully Presei	
Social Security Number (SSN): Foreign Passport Number:	· (	If lawful	lly present Non-Citizen, ent	er the following information:
If you do not have this information, enter y	our "A"	number and re	eceipt number or other immig	gration number:
Expected Tax Filing Status for the Current	Year (se	lect one for th	is child/tax dependent/othe	r household member)
☐ Single filing taxes			Adult disabled tax dep	endent of someone on the
☐ Head of household			application	
Qualifying widow(er) with tax dependent Tax dependent of someone on the application				
Married filing separately			Adult disabled tax department application	endent of someone <b>not</b> on the
Married filing jointly:			• •	eone <b>not</b> on the application
Name of primary tax filer:			Person has neither file	
			dependent	
Did you have the same tax filing status last year as the current year listed above? No Yes				
If no, list last year's tax filing status:  (Your response to this question does not affect your eligibility for Apple Health)				
If you are submitting this application betwe				xpect to file with the same tax
_		Yes	,,	
RACE / ETHNICITY CODE (OPTIONAL – chec	k all tha	tapply)		
If American Indian or Alaska native, do not ☐ White ☐ Black or African American ☐	_		-	Hispanic or Latino  Other
Are you an American Indian or Alaska Nativ				
(2.) List Children / Tax Depender	nts/Ot	her Househ	nold Members	
First Name M.I.	Last Na	me		Date of Birth (MM/DD/YYYY)
Is this Person Applying for Health Care Cove	erage	Sex	Relation to You (i.e. child, gra	I andchild, nephew, niece, sibling)
(For individuals not applying for coverage,	providi		l urity number (SSN) or citizen	ship status is optional)
Citizen or Non-Citizen Status: (check one)	-	_	Non-Citizen Lawfully Prese	· · · · · · · · · · · · · · · · · · ·
Social Security Number (SSN):				
Social Security Number (SSN):If lawfully present Non-Citizen, enter the following information: Foreign Passport Number:; Country of Issuance:; Date of Entry:				
If you do not have this information, enter y	our "A"	number and re	eceipt number or other immig	gration number:

Expected Tax Filing Status for the Cu	rrent Year (sele	ect one for th	is child/tax dependent/othe	r household member)
☐ Single filing taxes			Adult disabled tax dependent	endent of someone on the
☐ Head of household			application	
Qualifying widow(er) with tax dep	endent		Tax dependent of some	eone on the application
☐ Married filing separately			Adult disabled tax dependent	endent of someone <b>not</b> on the
Married filing jointly:			application	
Name of primary tax filer:			Tax dependent of some	eone <b>not</b> on the application
			Person has neither filed	d taxes nor was tax
			dependent	
Did you have the same tax filing status If no, list last year's tax filing status:	s last year as th	-	ar listed above?	28
(Your response to this question does	not affect you	r eligibility fo	or Apple Health)	
If you are submitting this application I status next year as you do this year?		. and 12/31 of ] Yes	f this calendar year, do you ex	spect to file with the same tax
RACE / ETHNICITY CODE (OPTIONAL -	· check all that a	apply)		
If American Indian or Alaska native, do	o not enter a ra	ice or ethnicit	ry .	
☐ White ☐ Black or African America	an 🗌 Asian 🛭	Native Haw	vaiian 🔲 Pacific Islander 🗌	Hispanic or Latino 🔲 Other
Are you an American Indian or Alaska	Native? No	o 🗌 Yes		
(3.) List Children / Tax Depe	ndents/Oth	er Housel	nold Members	
First Name	M.I. Last Nam	ne		Date of Birth (MM/DD/YYYY)
Is this Person Applying for Health Card	e Coverage	Sex	Relation to You (i.e. child, gra sibling)	ndchild, nephew, niece,
(For individuals not applying for cove	rage, providin	g a social sec	urity number (SSN) or citizen	ship status is optional)
Citizen or Non-Citizen Status: (check o	ne) 🔲 U.S.	. Citizen	Non-Citizen Lawfully Preser	nt In the U.S.
Social Security Number (SSN):		If lay	wfully present Non-Citizen, ei	nter the following information:
Foreign Passport Number:				
If you do not have this information, e				
			<u> </u>	_
Expected Tax Filing Status for the Cur	rront Voor (sol	act one for th	is shild /tay danandant /atha	r hausahald mambarl
Single filing taxes	Tent real (seit	ect one for th		endent of someone on the
Head of household			application	
	andant		Tax dependent of some	eone on the application
<ul><li>Qualifying widow(er) with tax dep</li><li>Married filing separately</li></ul>	endent		<del></del>	endent of someone <b>not</b> on the
Married filing jointly:			application	
Name of primary tax filer:			☐ Tax dependent of some	eone <b>not</b> on the application
Name of primary tax mer.			Person has neither filed	d taxes nor was tax
			dependent	
Did you have the same tax filing status	s last vear as th	e current vea	ar listed above? \( \subseteq No \subseteq Ye	<u> </u>
If no, list last year's tax filing status:		, , ,		
(Your response to this question does	not affect you	r eligibility fo	or Apple Health)	
If you are submitting this application I status next year as you do this year?	between 11/01			spect to file with the same tax
RACE / ETHNICITY CODE (OPTIONAL –		_		
If American Indian or Alaska native, do			·V	
☐ White ☐ Black or African America			- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Hispanic or Latino 🔲 Other
Are you an American Indian or Alaska	Native? No	o 🗌 Yes		

American Indian & Alaska Native	Information	
special benefits through the Health Benefit E	eligible for special Washington Apple Health (Medica exchange. Skip this section if no one you are applying he table below for anyone you are applying for that is	for is of American
Name of Person	Tribe Name	Member of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation
		□ No □ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		□ No □ Yes
Residency		
	ently resides in Washington, intends to reside in Wa ed the state looking for a job; or entered the state wi	
Is everyone applying for health care coverage If no, list anyone who is not a resident:	e a Washington State resident? No Yes	
Tobacco Use		
If yes, enter their name:	on regularly used tobacco products in the past 6 mor	nths? No Yes
(Your response to this question does not af	rect your eligibility for Apple Health)	
Adult Disabled Dependent  An adult disabled child is an individual who is household member for support.	s not capable of employment due to a disability and	is dependent on a
Do you have an adult child who is a disabled If yes, enter their name:	dependent 26 years or older? No Yes	
(Your response to this question does not aff	fect your eligibility for Apple Health)	
Jail and Prison Information		
<ol> <li>Are you or anyone you are applying f</li> <li>If yes, enter their name:</li> <li>Are disposition of charges pending?</li> <li>Is release date within 30 days?</li> </ol>	□ No □ Yes	
Voter Registration		
If you are not registered to vote where you	live now, would you like to apply to register to vote	e? 🗌 No 🗌 Yes
If you select "Yes" you will be provided a vot	er registration form.	
Applying to register or declining to register t your eligibility.	o vote will not affect the amount of assistance that y	you will be provided or
	registration application, you can receive assistance a The decision whether to seek or accept help is yours	_
· · · ·	vith your right to register to vote or to decline to reg er, you may file a complaint with the Washington Sta ons@sos.wa.gov, or call 1-800-448-4881.	<del>-</del>

f you do not want to apply for free or low cost coverage but you would like to purchase health care coverage hrough a Qualified Health Plan (QHP), sign here and do not complete Part 2 of the application.				
have read or had explained to me my Rights and Responsibilities.				
By signing this application you are agreeing to the Washington Healthplanfinder sharin state and federal agencies.	g your information with other			
Signature	Date			

Signature for Qualified Health Plan Applicants

You could be eligible for free or low cost coverage. To apply for Health Insurance Premium Tax Credits or Washington Apple Health (Medicaid), you must complete Part 2 of this application.

#### PART 2

Health Insurance Info	rmation				
Washington Apple Health (Me (Examples include private or e	edicaid or CHIP)? mployer sponsored ins	surance, Medicare, \	ets minimum essential coverage other to the section of the section	] No □Yes	
Insurance Company or Employer Name	Policy Number	Group Number	Policy Holder's / Employee's Name	Policy Holder's Date of Birth	
If yes, provide employer informally plan that meets the minimum.	mation in the table ab mum value standard. f the total allowed be rom your employer. ten paid (e.g., bi-wee	oove. Also, below lis An employer-spons nefit costs covered kly, monthly, annua		ost, employee- value	
Children's Health Insu	rance				
Skip this question and go to the Does your health insurance coulf yes, enter name:			mation) if you are not applying for cove	rage for a child.	
Have you dropped health insu If yes, when did the coverage		our children within t 	he last four months? No Ye	es .	
Unpaid Medical Bill In	formation				
Do you or anyone you are applying for need help paying for unpaid medical bills incurred in any of the 3 months immediately before the current month?   No Yes If yes, list who:					
Non-Citizen Emergency Medical Information					
Someone who is not a citizen and does not have any immigration status that makes it possible to get broad health care coverage still might qualify for more limited coverage.  Check all boxes that apply to any non-citizen you are applying for and enter their name in the space provided:  Has been treated for an emergency medical condition this month or during the previous three months:  Who:  Needs dialysis or cancer treatment: Who:  Needs anti-rejection medication as a result of an organ transplant: Who:  Needs nursing home, assisted living, or in-home care: Who:					
Pregnancy Informatio					
Are you or anyone in your hou	sehold pregnant?	No ☐ Yes (Us	se the second line if more than 1 woma	an is pregnant.)	
If yes, enter her name: Due Date: Number Expected:					
enter her name: Due Date: Number Expected:					

Gross Income Information							
This section helps us determine the amount of your household's modified adjusted gross income (MAGI). MAGI income must be used in order to determine if you are eligible for most health care coverage programs. Please answer the following questions for each household member you are applying for as accurately as you can.							
You are not required to provide income information for your dependents under age 19 who live in your home unless they are required to file a tax return. If you are under age 19 and living on your own, you must provide your gross monthly income. We will take the information you enter and use it to calculate the MAGI income for your household. Only enter information about the types of income we ask for because some types of income, such as child support, are not used to determine your monthly MAGI income.							
excludes from an AI/AN		do not have to report any AI/AN incom In addition, AI/ANs do not have to rep d in WAC 182-509-0340.					
		ome information for yourself and anyo required to file a tax return due to the					
If yes, enter the name o	f the person employed, r	ou or anyone you are applying for curre name of employer, and the employee's not enter self-employment income in the	s <i>current</i> gross monthly amount				
Name of Person Employed	Name of Employer	monthly income (wages salaries tins					
<b>Self-Employment Income:</b> Are you or anyone you are applying for currently self-employed?  No Yes If yes, please enter the current estimated net monthly income (profits once business expenses are paid) from self-employment. Please see page ii for allowable business expenses. <b>Note:</b> By answering yes to this question, you agree to provide additional documentation of income and expenses upon request by the agency.							
Name of Pers	Name of Person Employed  Name of Company (If there is one)  Net monthly income (do not enter corporation or S-corporation income here						
Employment Changes: Have you or anyone you are applying for experienced any of the following changes in circumstances?							
- Changed jobs in the past six months: No Yes If yes, who:							
- Stopped working in the past six months:							
- Started working in the past six months: No Yes If yes, who:							

Other Income					
NOTE: Do not include child support, non-			ntal Security Income (SSI)		
Check all that apply and tell us who gets i	t and how much and ho	w often.			
Alimony / Spousal Support	Who	\$ <u></u>	How often		
Dividend Payments Companies report this income to you on an IRS 1099-DIV form each year	Who	<u> </u>	How often		
Foreign Earned Income	Who	\$	How often		
Other Claimable Gains or Losses	Who	\$ <u></u>	How often		
Pension/Annuity/IRA	Who	. \$	How often		
Per Capita Income This is Economic Development funds from a tribe. An example of per capita income is distributions from gaming	Who	. \$ <u> </u>	How often		
Railroad Retirement .	Who	\$ <u></u>	How often		
Rental Income / Royalties This is monthly income from renting a home that wasn't included in selfemployment or monthly income from patents or other copyrighted work.		. \$ <u> </u>	How often		
☐ Social Security	Who	\$	How often		
Unemployment	Who	. \$	How often		
Deductions					
We ask you these questions because these of health care coverage, just like the IRS us you may still qualify for free or low cost he List below any deductions you claim on yo	ses them to reduce the a	amount of taxes yo	ou owe. If you choose not to answer,		
Alimony / Spousal Support	/ Spousal Support Health savings account Self-employment tax				
Student Loan Interest	dent Loan Interest Pre-tax retirement account payments (excluding Roth IRA contributions) Self-employment retirement plan				
Tuition and school fees	Moving costs since January of this year Self-employment health insurance premium				
	Who	\$	How often		
Deductions Type:\	Who	\$	How often		
☐ Deductions Type:\	Who	\$	How often		

Supplemental Information
Do you or anyone you are applying for need help with any of the following services?
a. Long-term care services because you are currently living in or expect to move to a medical institution, like
a nursing home. No Yes If yes, enter the name of the person:
Type of Facility:
b. An in-home care-giver? No Yes If yes, enter the name of the person:
c. Assisted Living care services? No Yes If yes, enter the name of the person:
d. Services through the Division of Developmental Disabilities?   No Yes
If yes, enter the name of the person:
e. Hospice care? No Yes If yes, enter the name of the person:
f. Do you need a disability determination because of a disabling condition expected to last 12 months or longer or
result in death? No Yes
You will be required to complete HCA form 18-005 if any of the following apply:
You are age 65 or older or on Medicare.
<ul> <li>You answered yes to any of the questions in a through fabove.</li> </ul>
<ul> <li>You are applying for the medically needy (MN) or the Healthcare for Workers with Disabilities programs (HWD).</li> </ul>
Read Carefully Before Signing
Disclosure of information to Other State and Federal Agencies:
In order to simplify the application/redetermination process, I authorize Washington Healthplanfinder to obtain my updated
federal tax information for a period of no more than five years.   No Yes I can change my consent at any time through the Washington Healthplanfinder.
I have read or had explained to me my rights and responsibilities and received a copy of <i>Client Rights and Responsibilities</i> .
Declaration and Signature
I have read and understood the information in this application. I declare, under penalty of perjury, the information I have
given in this application is true, correct, and complete to the best of my knowledge.
SignatureDate